I. **PURPOSE**

A. To assure that the University of California, Irvine Medical Center, through the activities of its Medical Staff, assesses the ongoing professional practice and competence of each practitioner with a staff appointment, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competency, practice, and patient care.

B. This policy refers to the records and proceedings of the Medical Staff, which has the responsibility of evaluation and improvement of the quality of care rendered in the Medical Center. The records and proceedings of the Medical Staff that relate to this policy in any way are protected from discovery pursuant to California Evidence Code, Section 1157.

II. **POLICY**

A. Ongoing Professional Practice Evaluation (OPPE) will be conducted on all practitioners with findings reported and evaluated by Department Chairs/Division Chiefs, the Professional Practice Evaluation Committee, the Medical Executive Committee, and the Governing Body Advisory Committee on a scheduled rotation with each Medical Staff Department/Division reporting every eight months.

B. The findings of these Committees will be used to ensure that decisions regarding appointment to membership on the medical/allied health professional staff and granting or renewing of privileges are detailed, current, accurate, objective and evidence-based.

C. A period of focused professional practice evaluation is required for all newly granted privileges and is accomplished through one or more of the following; direct observation, concurrent monitoring and retrospective monitoring. Focused evaluation for other purposes may include, but not be limited to, one or more of the following:

   1. Retrospective or concurrent chart review
   2. Monitoring of clinical practice patterns
   3. External peer review
   4. Simulation
   5. Discussion with other individuals involved in the care of the practitioner’s patients relative to the substance of the focused review.

D. A Focused Professional Practice Evaluation may be triggered by a specific or
single incident, a sentinel/adverse or “never” event or other evidence of trends in clinical practice or circumstances indicating that patient safety or professional practice may be compromised.

E. External professional practice evaluation will take place if deemed appropriate by the President of the Medical Staff or Director of Risk Management for:

1) Cases involving litigation, or the potential for a lawsuit as determined by the Director of Risk Management;

2) When dealing with vague or conflicting recommendations from internal reviewers; or

3) Lack of internal expertise

III. DEFINITIONS

A. **Focused Professional Practice Evaluation (FPPE):**

An intense assessment of a practitioner’s credentials and current competence. FPPE applies to:

1) Provisional practitioners and to practitioners who request new expanded privileges;

2) Practitioners with an existing privilege, but lacking the volume of cases needed to assess competence; and

3) Practitioners with an existing privilege, but with performance concerns.

B. **Ongoing Professional Practice Evaluation (OPPE):**

A process, applied to practitioners already granted patient care privileges, which allows the medical staff to monitor on an ongoing basis, professional practice trends that impact quality of care and patient safety. This process includes:

1) The evaluation of an individual practitioner’s professional performance based on the following general areas.
   i. Professional Standing
   ii. Lifelong learning and self-assessment
   iii. Cognitive expertise (Board Certification)
   iv. Professionalism and Interpersonal skills
   v. Evaluation of Performance in Practice (Department specific indicators supported by administrative data bases)

2) Practitioner-relevant and practitioner-specific measures or indicators, activity data, and other information needed to objectively assess a practitioner’s ability to provide safe, effective, and appropriate care. These will be determined by individual Departments and approved by the Medical Executive Committee.

3) Opportunities to improve care based on recognized standards. OPPE
differs from other performance improvement processes in that it evaluates the individual practitioner’s performance and competence related to their privileges rather than appraising the quality of care rendered by a group of professionals or by a system.

C. **Professional Practice Evaluation Committee (PPEC):**
A multidisciplinary medical staff committee whose function is to review aggregate data and individual case review data for the purpose of identifying trends and further actions needed based on review of the data.

D. **Peer Review:**
A method whereby physicians and other healthcare professionals objectively assess a peer’s judgments and actions. Goals of peer review are to focus on the professional services of the individual reviewed and toward the overall goal of assessment and enhancement of quality.

E. **Practitioner:**
Medical staff members and allied health professionals who practice at the University of California, Irvine Medical Center.

IV. **PRINCIPLES**
A. **Confidentiality**
1. Professional practice evaluation information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws (including California Evidence Code Section 1157), and regulations pertaining to confidentiality and non-discoverability.

2. Professional practice evaluation information is available only to authorized individuals who have a legitimate need to know this information, based upon their responsibilities as a medical staff leader or Medical Center employee. They shall have access to the information only to the extent necessary to carry out their assigned responsibilities. Only the following individuals shall have access to provider-specific professional practice evaluation information, and only for the purposes of performance improvement and as part of their official duties.

   a. Medical Staff Officers
   b. Chief Medical Officer
   c. Chief Executive Officer
   d. Medical Staff Department Chairs/Division Chiefs for members of their respective departments only
   e. Members of the Professional Practice Evaluation Committee, members of the Medical Executive Committee and Governing Body Advisory Council
f. The involved practitioner (his/her specific data and aggregate data only)

g. Risk Management staff, Performance Improvement staff, and Medical Staff Services professionals to the extent that access to this information is necessary for the reappointment process or formal corrective action

h. Individuals surveying for accrediting bodies with appropriate jurisdiction (The Joint Commission or state/federal regulatory bodies)

B. Reliability of review process

1. Professional practice evaluation is conducted in a manner that is objective, equitable, and consistent.

a. Case selection is done by use of pre-selected measures or indicators.

b. Review of cases is performed by committee members in accordance with procedures listed in Section V.

2. Follow-up is conducted and reported to the Professional Practice Evaluation Committee.

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<thead>
<tr>
<th>V. PROCEDURE</th>
<th>RESPONSIBLE PERSON(S)/DEPT.</th>
<th>PROCEDURE</th>
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<tbody>
<tr>
<td>A. CURRENTLY PRIVILEGED PRACTITIONERS: ONGOING PROFESSIONAL PRACTICE EVALUATION</td>
<td>Department Chair/Division Chief and Clinical Performance Improvement Advisor</td>
<td>1. Each Department Chair/Division Chief identifies indicators and other information needed to objectively assess a practitioner’s ability to provide safe, effective, and appropriate care. Pre-determined thresholds for each indicator, as appropriate, are also determined.</td>
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<td>Department Chair/Division Chief and Clinical Performance Improvement Advisor</td>
<td>2. Indicators and thresholds are to be evaluated periodically to determine if modification is needed.</td>
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<td>Clinical Performance Improvement Advisor</td>
<td>3. Aggregate data is obtained from the most reliable data sources for each indicator, and is entered on to the Department/Division scorecard.</td>
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<td>Clinical Performance Improvement Advisor</td>
<td>4. Department/Division Scorecards are reviewed by the Chair/Chief prior to the Professional Practice Evaluation Committee Meeting.</td>
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<td>Clinical Performance Improvement Advisor and Department Chair/Division Chief</td>
<td>5. Individual case/peer reviews, based on significant clinical events identified by sources such as incident reports, patient/family complaints, referral from M&amp;M Committees, referral from other practitioners, and sentinel and “never” events, are reviewed by the Department Chair/Division Chief.</td>
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<td>Professional Practice Evaluation Committee</td>
<td>6. When a threshold is exceeded or a concern is raised relative to a practitioner’s current clinical competence, practice, behavior and/or ability to perform any of his/her privileges, the Professional Practice Evaluation Committee, will determine one of the following:</td>
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a. Issue(s) exist that require a focused evaluation;
b. Zero performance, triggering a focused review whenever the practitioner actually performs the privilege;
c. Follow-up action to include, but not limited to, counseling by Chair, Performance Improvement initiative, physician enrollment in education/remediation programs (e.g., PACE);
d. After further review, the practitioner is performing within desired expectation and no further action is warranted.

### B. FOCUSED PROFESSIONAL PRACTICE EVALUATION

| Chair, Professional Practice Evaluation Committee | 1. A subcommittee of the Professional Practice Evaluation Committee, including support staff from the Department of Performance Improvement, will conduct the focused evaluation. |
| Professional Practice Evaluation Committee/Clinical Performance Improvement Advisor | 2. The duration and type of monitoring will be determined based on the nature/severity of the situation under evaluation, the type of privilege(s) in question, and the practitioner’s activity level. The initial review period may be extended based on the extent to which sufficient information has been obtained. Similarly, the initial method of evaluation may be expanded or supplemented with other methods as needed. |
| Manager, Medical Staff Administration | 3. A letter will be sent to the affected practitioner to notify him/her of the focused evaluation, the reason for the evaluation, the duration of the evaluation, and type of monitoring that will occur. If during the evaluation, information is needed by members of the reviewing subcommittee, a letter may be sent to the practitioner requesting input, or the practitioner may be requested to provide input in person. |
| Chair, Professional Practice Evaluation Committee/Manager, Medical Staff Administration | 4. Upon completion of the focused evaluation, findings will be reported to the Professional Practice Evaluation Committee, and, upon review, will make a recommendation(s) that may include, but not be limited to:  
   a. No further action required;  
   b. Current competence issues exist with the need for additional education and training;  
   c. Impairment is suspected with referral to Well Being;  
   d. There are immediate threats to patient safety for which consideration of suspension of relevant privileges is necessary. |
| Manager, Medical Staff Administration | 4. The respective Department Chair/Division Chief will receive notification of the findings of the focus evaluation. |
| Manager, Medical Staff Administration | 5. A letter will be sent to the affected practitioner regarding the results of the focused review and any recommendation(s). |
| Medical Staff Administrative Analyst | 6. All findings and actions taken will be documented in the practitioner’s credential file for review and reference at reappointment. |

### VI. REFERENCES

- Medical Staff By-Laws, November 17, 2008
- Rules and Regulations of the Medical Staff, August 18, 2008
- The Joint Commission Hospital Accreditation Program, Medical Staff Chapter 2009
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Approvals: Credentials Committee 09/03/09
Medical Executive Committee 09/14/09
Governing Body 09/21/09